2. With respect to MediPASS, the contracts Iowa enters into with PMs will contain (at a minimum) all terms required under section 1905(t)(3). Reimbursement will be made on a fee-for-service basis, with a $2.00 monthly case management fee for each MediPASS recipient assigned. The following is a list of the types of providers that qualify to be primary care providers under the MHC program: physicians (pediatricians, family practitioners, internists, general practitioners, obstetrician/gynecologists), FQHCs, RHCs).

   Certified nurse practitioners are not included as a PCCM type; however these services will be made available: The Department covers these services in the same manner as fee-for-service. The only difference is that a referral from the MediPASS provider is required for reimbursement of the services. Any Iowa Medicaid provider of this type is able to see and treat a MediPASS recipient with the required referral.

   Nurse midwives are not included as a PCCM type, however these services will be made available: The Department covers these services in the same manner as under fee for service. The only difference is that a referral from the MediPASS provider is required for reimbursement of the services. Any Iowa Medicaid provider of this type is able to see and treat a MediPASS recipient with the required referral.

3. All participating primary care case managers shall be required to sign a MediPASS participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PCCM shall be required to specify the number of recipients the PCCM is willing to serve as primary care case manager. Unless circumstances exist which require the Department to authorize a higher quota for a PCCM to ensure adequate coverage in an area, the maximum shall be 1,500 recipients per primary care case manager. In addition, the Department does increase the enrollment limit by 300 for MediPASS providers that have a physician assistant participating in the program. (See also Item M.12.)

4. Primary care case managers under the MHC program must:

   a. Be Medicaid-qualified providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 (and new requirements in 42 CFR 438 when final) and all State plan standards regarding access to care and quality of service;

   b. Sign a contract or addendum for enrollment as a primary care case manager which explains the primary care case manager's responsibilities and complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: making available 24-hour, 7 days per week access by telephone to a live voice (an employee of the primary care case manager or an answering service) or an answering machine which will immediately page an on-call medical professional for information, referral, and treatment of medical emergencies; referrals for non-emergency services; or to information about accessing services or how to handle medical problems during non-office hours;

c. Provide comprehensive primary health care services to all eligible Medicaid beneficiaries who choose or are assigned to the primary care case manager's practice;

d. Refer or have arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

e. Have hours of operations that are reasonable and adequate. The MediPASS provider must have the same hours of operation for the MHC enrollees as they have for their other patients. The Department requires all MediPASS providers to have 24-hour access via telephone. This does allow for another provider to be on-call for the MediPASS provider during non-office hours. The MediPASS provider must respond to a referral request phone call within 30 minutes;

f. Not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

g. Take beneficiaries in the order in which they enroll with the primary care case manager;

h. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;

i. Restrict enrollment to people residing sufficiently near a service delivery site of the primary care case manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

5. Qualifications and requirements for PMs are noted in the provider agreements. MCOs and MediPASS PMs shall meet all of the following requirements:

a. An MCO shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

b. The MCO shall sign a certification agreement that explains the responsibilities MCOs must comply with.

c. The MCO shall have a state-approved grievance and appeal process.

d. The MCO or MediPASS PM shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the MCO or MediPASS Program.

e. The MCO or MediPASS PM shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

f. The MCO or MediPASS PM shall make available 24-hour, 7-day-a-week access by telephone to a live voice (an employee of the MCO or a representative or a representative of the MediPASS PM) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.

g. The MCO or MediPASS PM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

h. The MCO or MediPASS PM shall request reassignment of the participant to another MCO or MediPASS PM only if the patient/provider relationship meets "good cause" reasons. The Department does allow MCOs and PCCMs to request that an enrollee be disenrolled or prohibited from enrolling for good cause. All reassignments must be state-approved. Good cause is defined as enrollment harmful to the enrollee or the MCO, excluding the enrollee's health or a change therein which may have an adverse financial effect on the MCO.

The Department reviews all 'good cause' reasons for transfer on a quarterly basis via the reports from the enrollment broker. The Department meets with the enrollment broker weekly to review all current issues, including any requests for disenrollment by any MediPASS provider or MCO.

i. All MCO subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.

j. The MCO shall be licensed by the Division of Insurance in the Iowa Department of Commerce in order to ensure financial stability (solvency) and compliance with regulations.

k. Access to medically necessary emergency services shall not be restricted. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

l. Iowa ensures enrollee access to emergency services by requiring the MCO/PHP/PCCM to provide adequate information to all enrollees regarding emergency service access.

m. Iowa ensures enrollee access to emergency services by including in the contract requirements for MCOs/PHPs/PCCMs to cover the following.

(1) The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

(2) The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

(3) Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

(4) Continued emergency services until the enrollee can be safely discharged or transferred,

(5) Post-stabilization services that are pre-authorized by the MCO/PHP or primary care case manager, or were not pre-authorized, but the MCO/PHP or the primary care case manager failed to respond to request for pre-authorization within one hour, or could not be contacted. Post-stabilization services remain covered until the MCO/PHP or primary care case manager contacts the emergency room and takes responsibility for the enrollee.

J. Additional Requirements

1. Any marketing materials available for distribution under the Act and state statutes shall be provided to the Department for its review and approval.

2. The MCO shall certify that no recipient will be held liable for any MCO debt as the result of insolvency or for services Iowa Medicaid will not pay for.

3. The MCO shall include safeguards against fraud and abuse, as provided in state statutes.

4. The MCO shall allow the state to take sanctions as prescribed by federal or state statutes. Also, the MCO shall provide assurance that due process will be provided.

K. FQHC and RHC Services

The program is **mandatory** and the enrollee is guaranteed a choice of either an FQHC as a primary care case manager, a primary care manager that contracts with an FQHC, or at least one MCO/PHP which has at least one FQHC as a participating provider.

If the enrollee elects not to select a managed care choice that gives access to FQHC services, no FQHC services are required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PHP/PCCM selected. In any event, since reasonable access to FQHC services will be available under the MHC program, FQHC services outside the program will not be available.

All of the FQHCs in the state are participating in the MediPASS program. This allows any recipient to be able to select the FQHC as the primary care case manager. In addition, the MCO contract specifically mentions the encouragement to contract with FQHCs in the service area. FQHC reimbursement will follow all applicable federal requirements. The MCOs must pay FQHCs and RHCs rates comparable to non-FQHC and RHC providers. Iowa pays prospective payments in accordance with the approved Iowa State Plan.

L. Quality of Health Care and Services, Including Access

1. Iowa requires all MCOs and providers, by contract, to meet state-specified standards for internal quality improvement programs (QIPs).

2. On a periodic or continuous basis, Iowa monitors the adherence to these standards by all MCOs, through the following mechanisms:

   a. Review of the written QIP for each MCO to monitor adherence to the Iowa QIP standards. Such review shall take place at least annually.

   b. Periodic review of numerical data or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the Department as required by the contract with the MCO.

   c. Monitoring of the implementation of the QIP to ensure compliance with Iowa QIP standards. This monitoring is conducted on-site at both the MCO administrative offices and the care delivery sites, as necessary. At least one such monitoring visits shall occur per year.

   d. Monitoring through the use of Department personnel and contracted staff.

3. The Department will arrange for an independent, external review of the quality of services delivered under each MCO's contract with the state. The review will be conducted for each MCO contractor on an annual basis. The entity which provides the annual external quality reviews shall not be a part of the state government, an MCO, or an association of any MCOs.

4. Recipient access to care will be monitored as part of each MCO's internal QIP and through the annual external quality review for MCOs. The periodic medical audits, state monitoring activities and the external quality review shall all derive the following information:

   a. Periodic comparisons of the number and types of Medicaid services before and after the institution of the MHC Program.

   b. Recipient satisfaction surveys managed by state staff.

   c. Periodic recipient surveys which the MCOs will conduct containing questions about recipient access to services.

   d. Measurement of waiting periods to obtain health care services; including standards for waiting time and monitor performance against these standards.

   e. Measurements of referral rates to specialists.

   f. Assessment of recipient knowledge about how to obtain health care services.

   g. Utilization and encounter data submitted by MCOs .

M. Access to Care

Iowa assures that recipients will have a choice between at least two MediPASS PMs or a combination of one MCO and the MediPASS program. When fewer than two choices are available in the geographic area, the managed care program is voluntary. In addition to this process, the MHC program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating MCOs or MediPASS PMs in the service areas. In addition, as per 42 CFR 434.29, within an MCO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the MHC Program.

3. Access standards for distances and travel miles to obtain services for recipients under the MHC program have been established. Specifically, the MHC program must have a primary care provider within 30 miles or 30 minutes.

The Department utilizes the 30-mile/30-minute guideline for all MHC providers. This is applied to the MCOs at the time they request service to a new county, as well as quarterly thereafter. The Department requires the enrollment broker to review each county for PCP access on a quarterly basis in the MediPASS program. This report is submitted to the Department for review.

The Department realizes that there are rural portions of the state that simply do not have certain specialists within a 30-mile/30-minute radius. At the time of MCO expansion, the external quality review organization will review the specialist panel for adequacy. This is based on a knowledge of the existing pool of specialists and whether there are a sufficient number of specialists in the panel of the MCO to service the enrollment level of the area.

The MediPASS option allows the PCP to give a referral to any Iowa Medicaid provider, thus the panel of specialists would be the entire Iowa Medicaid provider network. This allows any MediPASS enrollee to see any specialist that accepts Iowa Medicaid. Therefore, this network is no less than the network available to a person not in the MHC program.

The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. The number of providers to participate under the MHC program is expected to increase.

5. Primary care and health education are provided to enrollees by a chosen or assigned MCO or MediPASS PM. This fosters continuity of care and improved provider/patient relationships.

6. Pre-authorization is precluded for emergency care and family planning services under the MHC Program.

7. Recipients have the right to change plans at any time if good cause is shown.

8. MCOs and MediPASS PMs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

9. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E. The same appeals hearing system in effect under the Medicaid fee-for-service program is in effect under the MHC program.

10. Iowa assures that state-determined access standards are maintained by quarterly analysis of provider panels.

11. Under the terms and conditions of their existing contracts, MCOs must:

    a. Assure that covered services are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities.

    b. Provide to enrollees and prospective enrollees: an informational letter written in the applicable language explaining the MCO policies, a toll-free number to obtain further information about the MCO in the applicable language, all enrollment materials written in the applicable language, and translation services when necessary to ensure delivery of covered services.

    c. Inform a non-English-speaking enrollee about any provider who speaks the same non-English language, if the MCO is aware of any such provider.

12. Iowa has a limit (1,500) on the number of recipients that can be managed by a physician in the MHC program in effect under the MHC program. The limit guarantees access to appointments within acceptable time parameters for urgent and illness-related conditions as well as non-symptomatic preventive care. The number of Medicaid recipients also allows for the PM to serve a sufficient number of private-pay and commercially insured patients to create a mixture of patients reflective of the insurance status of the community may be required.

    The Department has designated a maximum limit for a MediPASS providers of 1,500 per provider. The Department allows an additional 300 enrollment for MediPASS providers with a physician assistant participating in the program. Contracted MCOs are expected to hold this requirement as part of the evaluation of provider panels for individual counties in which they are approved for participation.

    There has been one exception to this limit in regards to the FQHC in Polk County. As Polk County has over 15,000 Iowa Medicaid recipients eligible for the MHC program, this county has the largest concentration of enrollees in the state. The FQHC has satellite clinics that serve a large portion of the county. For these reasons, the Department has allowed the FQHC in Polk County to have a maximum enrollment limit of 2,500 enrollees. With the expansion of two MCO options into Polk County, the actual MediPASS enrollment to the FQHC has remained around 500 to 600 enrollees.